CATCH — Country Access To Cardiac Health.

# REFERRAL - CARDIAC REHABILITATION

| U.R NO: | |
|---|---|
| TITLE: | SURNAME: |
| GIVEN NAMES: | |
| ALIAS: | |
| D.O.B ____/____/____ | GENDER: |
| MEDICARE NO. | |
| DVA ☐Yes ☐ No | DVA NO. |
| Complete details or affix client identification label | |

All enquiries to (08) 8201 7798 Monday to Friday 9am – 5pm

**SEND COMPLETED REFERRAL TO:**

- E-mail health.chsacardiacrehab@health.sa.gov.au
- Fax- (08) 8201 2597

**Complete all relevant sections (Please print clearly)**

| | | | |
|---|---|---|---|
| **Client/patient contact details** | Address 1 | City/suburb | |
| | Address 2 | Postcode | State |
| | Phone | Mobile | |
| | Aboriginal or Torres Strait islander ☐ Yes ☐ No | | |
| | E-Mail: | Public Cardiac Rehab ☐ | Private Cardiac Rehab ☐ |
| **Hospital admission details** | Date of admission | Date of discharge | Transferred to |
| **Inpatient cardiac rehabilitation review** | Was this person reviewed by a cardiac rehabilitation nurse whilst an inpatient in hospital? | ☐ Not applicable<br>☐ Yes<br>☐ No | Phase 1 Completed<br>☐ Yes<br>☐ No |
| **Referrer details** | Referrer Name | Role and Organisation name | Date of Referral |
| **Cardiologist details** *(if applicable)* | Cardiologist Name | | |
| | Organisation and/or Address | | |
| **Client/patient's GP or other primary health care provider details** | Name | Organisation | |
| | Address | | |
| | Telephone | Fax | |
| **Has the client/patient been given the following written resources?** | MY HEART MY LIFE | ☐ Yes ☐ No | ☐ Unknown |
| | MY HEART MY FAMILY OUR CULTURE | ☐ Yes ☐ No | ☐ Unknown |
| **Principal diagnosis/reason for referral** | | | |
| **Current medications** *(Attach list if necessary)* | | | |
| **Relevant medical history summary** *(Attach list if necessary)* | | | |

| **Risk Profile** | LDL | HDL | Trig | Total Chol |
|---|---|---|---|---|
| **Test Date:** | Height(m) | Weight(kg) | Smoker/Ex Smoker | BP |

CARDIAC REHABILITATION – REFERRAL COUNTRY SOUTH AUSTRALIA